

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER The Villas at Osseo LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Second Street Southeast Osseo, MN 55369	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>47083</p> <p>Based on observation, interview and document review, the facility failed to provide medication as ordered by the physician for 3 of 3 residents (R1, R2, R3) reviewed for pharmacy services.</p> <p>Findings include:</p> <p>R1's Physician's Orders dated 8/21/24 directed to hold warfarin (generic name for Coumadin, a blood thinner) 8/21/24 and 8/22/24. Recheck INR (international normalized ratio, a lab test for blood clotting) on Friday 8/23/24.</p> <p>R1's August MAR indicated R1 did not receive Coumadin from 8/23/24 through 8/27/24.</p> <p>On 9/6/24 at 12:25 p.m., case manager (CM)-A stated licensed practical nurse (LPN)-C entered the order into the computer system incorrectly, which lead to the omission of the lab being completed as ordered. R1 missed Coumadin dosages 8/23/24 through 8/27/24.</p> <p>On 9/10/24 at 9:04 a.m., LPN-C stated she made an error when entering the lab order into the computer system, for R1's INR, causing it to be missed on 8/23/24.</p> <p>R2's Physician's Orders dated 9/4/24 directed to administer niacin (a form of vitamin B3) 500 milligrams (mg) by mouth daily in the morning.</p> <p>On 9/5/24 at 7:26 a.m., a progress note indicated the niacin was on order from the pharmacy.</p> <p>On 9/6/24 at 11:29 a.m., a progress note indicated the pharmacy was contacted, and the medication was a house stock. The medication was not in the medication room. It would be ordered by the person who orders stock medication.</p> <p>R2's September medication administration record (MAR) indicated R2 did not receive niacin 500mg on 9/5/24 or 9/6/24.</p> <p>On 9/6/24 at 11:24 a.m. LPN-A stated there was no niacin in stock. She was not sure when the medication was expected to arrive. She had not yet informed her supervisor the medication was not in stock. The provider had not been notified R2 had not received the prescribed medication for two days.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/6/24 at 1:24 p.m., CM-A stated while the over-the-counter (OTC) medications were typically obtained through a vendor, they did have a process in place to obtain the OTC medications through their contracted pharmacy. The provider should be informed if a medication was missed.</p> <p>On 9/6/24 at 3:08 p.m. R2 stated she was not made aware of any missed medications.</p> <p>On 9/6/24 at 3:26 p.m., nurse practitioner (NP)-A stated R2 was prescribed niacin for hypertension (high blood pressure) and stated R2 needed the niacin.</p> <p>R3's Physician's Orders dated 8/21/24 directed to administer one nicotine patch 21micrograms (mcg)/hour transdermal (topical to the skin) in the morning.</p> <p>R3's Physician's Orders dated 9/4/24, directed to administer one nicotine patch 21mcg/hour to skin in the morning.</p> <p>On 8/22/24 at 11:08 a.m., a progress note indicated the nicotine patch was on order.</p> <p>On 8/23/24 at 11:06 a.m., a progress note indicated the nicotine patch was on order.</p> <p>On 9/4/24 at 8:32 a.m., a progress note indicated the nicotine patch was on order.</p> <p>On 9/5/24 at 9:13 a.m., a progress note indicated the nicotine patch was not given.</p> <p>R3's August MAR indicated R3 did not receive the nicotine patch on 8/22/24 or 8/23/24.</p> <p>R3's September MAR indicated R3 did not receive the nicotine patch on 9/4/24, 9/5/24, or 9/6/24.</p> <p>On 9/6/24 at 11:35 a.m. LPN-A stated R3 did not have her nicotine patch to apply as prescribed.</p> <p>On 9/6/24 at 12:56 p.m., the administrator stated stock medications were typically ordered through a vendor, but if a new resident was admitted with a medication they did not have in stock, they would obtain the medication through their contracted pharmacy or other means.</p> <p>On 9/6/24 at 2:15 p.m., LPN-A stated she was unable to locate a nicotine patch for R3. She had made a progress note in R3's chart. She was not sure how long R3 had been without the medication. LPN-A stated the medication was due to have been administered between 7:00 a.m. to 11:00 a.m. She had not notified the provider or her supervisor, nor had she started a medication error report form.</p> <p>On 9/6/24 at 2:44 p.m., R3 stated she would like to have a nicotine patch on. R3 stated she was not sure why she did not have one on.</p> <p>On 9/6/24 at 4:02 p.m., CM-A stated the pharmacy makes several deliveries each day. CM-A stated he was not made aware of R2 or R3's missing medications by nurses.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility document Medication Administration dated 4/2018, directed if a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time documentation of the unadministered dose is done as instructed by the procedures for use of the electronic medication administration record system. Nursing documents the notification and physician response.</p> <p>A facility document Medication Error Procedure, dated 1/2020, directed medication errors should be assessed, documented, and reported according to federal and/or state guidelines as appropriate.</p> <p>An undated facility document Medication Not Available Algorithm directed if medication is not available in med bank (an on site medication source), then call provider to notify medication not available and get order to hold until obtained from pharmacy or temporary orders for alternative medication that is in the med bank. Document notification in computer charting system and what provider orders/directions are. Then call pharmacy to order medication and tell to send on next run. Document that this was done in computer charting system to notify clinical leaders. Document any other reasons why medication may not be able to be sent. Notify family of provider orders in regards to medication not being available.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083</p> <p>Based on observation, interview and document review, the facility failed to maintain infection control practices while conducting blood glucose checks for 2 of 4 patients (R1, R4) reviewed for medication administration.</p> <p>Findings include:</p> <p>R1's MDS admission Minimum Data Set, dated dated dated [DATE] indicated R1 had a diagnosis of diabetes mellitus.</p> <p>R1's Physician's Order dated 8/31/24, directed to check blood glucose before meals and at bedtime.</p> <p>On 9/6/24 at 11:41 a.m., licensed practical nurse (LPN)-A placed a bin containing blood glucose testing supplies, including a shared glucometer, on the nightstand in R1's room. LPN-A placed the glucometer on the bed linens while she prepared R1's finger, then set the glucometer on the over-the bed table once she had the blood sample applied to the test strip. LPN-A removed the test strip and wiped the glucometer with an alcohol wipe, and immediately placed the glucometer back in the bin.</p> <p>LPN-A stated she was not aware of any other cleaning requirements for the glucometer other than an alcohol wipe.</p> <p>R4's MDS admission MDS dated [DATE] indicated R4 had a diagnosis of diabetes mellitus.</p> <p>R4's care plan dated 7/16/24 directed monitor residents blood sugar as ordered.</p> <p>R4's Physician's Order dated 8/20/24 directed to inject sliding scale insulin with meals, based on blood glucose.</p> <p>On 9/6/24 at 12:18 p.m., LPN-B placed a bin containing blood glucose testing supplies on the over-the bed table in R4's room. LPN-B removed the glucometer and placed it directly on the over-the-bed table. Following the procedure, LPN-B placed the glucometer directly into the bin, without disinfecting it. LPN-B brought the bin to the medication cart, then removed the glucometer, wiped it with an alcohol wipe and set it back into the bin. LPN-B stated she thought she was supposed to wipe the glucometer with an alcohol wipe.</p> <p>On 9/6/24 at 12:25 p.m., clinical manager (CM)-A stated ideally each resident would have their own glucometer. e. CM-A stated the glucometers were expected to be cleansed with the designated disinfectant wipes which would remain in contact with the glucometer for a full two minutes.</p> <p>On 9/10/24 at 8:40 a.m., CM-A and the administrator stated there were a total of four residents using the two shared glucometers on 9/6/24 in the transitional care unit (TCU).</p> <p>An undated facility document Cleaning Glucometer Procedure directed after blood sugar is obtained, remove the strip and wipe down the glucometer with a bleach wipe. Take a second bleach wipe and keep the meter wrapped in the wipe for one minute.</p>		